UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION

GILENYA (fingolimod)

Patient name:_____Medicaid ID #:_____

Prescriber Name:_____Prescriber NPI#:_____ Contact person:_____

Prescriber Phone#:_____Extension/Option:_____ Fax#:_____

Pharmacy:_____Pharmacy Phone#:_____Pharmacy Fax #:_____

Requested Medication:_____Strength:_____Frequency/Day:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES AND THIS COMPLETED FORM TO (801) 536-0477

CRITERIA:

- Minimum age requirement: 18 years old.
- Documented diagnosis of relapsing-remitting Multiple Sclerosis.
- Dose limited to less than or equal to 0.5mg once daily.
- A written plan to monitor for bradyarrythmia in-office or clinic for six hours following the first dose.
- Baseline test values (within the preceeding six months):
  - CBC
  - LFT
  - ECG
  - ophthalmic exam

AUTHORIZATION:

Initial authorization will be granted for three months

RE-AUTHORIZATION:

Updated letter of medical necessity